STATE OF NEW JERSEY

STATE EMPLOYEE GROUP DENTAL PROGRAM

THE DENTAL EXPENSE PLAN AND THE DENTAL PLAN ORGANIZATIONS

Division of Pensions and Benefits

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The benefits and provisions of the State Employee Group Dental Program are subject to changes by the legislature, courts and other officials. While this booklet outlines the benefits of the Program, it is not a final statement.

As an employee of the State of New Jersey, you are entitled to enroll in either the Dental Expense Plan offered by Prudential, or one of the many Dental Plan Organizations participating in the State Employee Group Dental Program. You may also choose not to enroll in any dental plan at all.

The group dental program is open to state employees who are eligible to participate in the State Health Benefits Program.

SECTION ONE
GENERAL INFORMATION

INTRODUCTION

This booklet describes the two dental benefit plans that are available to eligible full-time employees of the State, State universities and colleges, and certain independent agencies. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations and exclusions of the coverage under each plan. The complete terms of the State Group Dental Program are described in the Dental Expense Plan document with amendments and the Dental Provider Organization contracts.

Enrollment in a dental plan is optional. If you do not enroll when first eligible, you will have the option to enroll each year during the Annual Open Enrollment Period.

The dental program provides a choice between two different plans:

- The **Dental Expense Plan** is a traditional indemnity plan that allows you to obtain services from any dentist. After you satisfy the $25.00 annual deductible, you are reimbursed for 80% of the reasonable and customary charges for the services that are covered under the plan. This plan is administered, under contract with the State Health Benefits Commission (SHBC), by Prudential Insurance Company.

- The **Dental Plan Organizations** are individual prepaid plans offering services through a network of dental providers. You may enroll in one of several Dental Plan Organizations (DPOs). To obtain services, you must use a dentist who is a member of the DPO you selected. The cost for most services are prepaid, but certain services require an additional co-payment. You will not be covered for services if you go to a dental provider who is not a member of your DPO, unless referred by a DPO dentist.

The cost for participation in either plan is shared equally by the State and you. Your premium payments are made through payroll deductions. For a current list of rates and payroll deduction schedules, please see your benefits administrator. Employee premiums can be paid on a pre-tax basis through participation in the Premium Option Program (POP) of the State's IRC Section 125 Program, Tax$ave. Participation in POP is automatic unless you specifically decline enrollment.

In deciding whether to enroll and which plan to choose, you should consider the differences in out-of-pocket costs, the covered services between the Dental Expense Plan and a DPO and the degree of flexibility that you may want in selecting a dentist. You should also recognize that you must remain in any plan you select for at least 12 months.

WHO IS ELIGIBLE TO ENROLL?

You are eligible to enroll in the State Dental Program if you are a ***full-time employee*** of:

The State of New Jersey
Rutgers, the State University of New Jersey
New Jersey Institute of Technology
University of Medicine and Dentistry of New Jersey
The College of New Jersey

Jersey City State College
Kean University
Montclair State University
Ramapo College of New Jersey
Rowan University
The Richard Stockton State College of New Jersey
Thomas Edison State College
The William Paterson University of New Jersey
Palisades Interstate Parkway Commission
Waterfront Commission of New York Harbor
The State Legislature

and have completed the required waiting period.

Generally, you are considered to be a full-time employee if:

- You are employed for at least 35 hours per week on a 10- or 12-month basis.

In the description of enrollment procedures, this booklet makes reference to Bi-weekly employees and Monthly employees.

- Bi-weekly employees are paid through the State's centralized payroll with benefits provided on a bi-weekly pay period basis.

- Monthly employees are employees of State universities and colleges, State legislators and aides, and independent agencies. Their benefits are provided on a calendar-month basis.

WHAT LEVELS OF COVERAGE ARE AVAILABLE?

There are four levels of coverage:

- Single: covers the employee only
- Member and spouse: covers the employee and his/her spouse
- Parent and child: covers the employee and all enrolled eligible children
- Family: covers employee, spouse and all enrolled eligible children

WHICH DEPENDENTS ARE ELIGIBLE TO ENROLL?

If you enroll, you may also enroll the following dependents:

- Your spouse.

- Your unmarried children (including step-children, legally adopted children, foster children and legal wards) under the age of 23 who are substantially dependent upon you for support and maintenance and who:

    - *live with you in a normal parent-child relationship; or*

    - *reside at school but who have a permanent domicile with you and whom you support; or*

- *do not live with you, but whom you are legally required to support. Proof of the legal requirement of support is necessary.*

WHEN ARE DEPENDENTS NOT ELIGIBLE?

Dependents are not eligible for coverage as follows:

- Child over age 23 at the time of enrollment.
- A child's eligibility ends on December 31 of the year in which the child reaches age 23.
- Your child no longer resides with you in a parent/child relationship.
- Upon divorce, your ex-spouse is not eligible.
- You are divorced and the child does not live with you and you are not legally required to support your child.
- If a child marries before reaching age 23, eligibility ends on the date of the marriage.
- A child is not eligible if on active duty in the armed forces of any country.
- Neither you, your spouse nor your children are eligible if you or your spouse are eligible for dental coverage through active service in the armed forces.
- Your spouse or a child is not eligible if your spouse or child is already covered in the Program as an employee or a dependent of another employee.
- If you and your spouse are both covered as employees, a child can only be listed as a dependent on one coverage.

WHEN CAN YOU ENROLL?

- A new employee may enroll the first month of employment, provided the State Health Benefits Program (SHBP) receives the application within the sixty days of employment, or
- Any employee who did not enroll when first eligible may enroll during the Annual Open Enrollment Period.
- If you did not enroll because of other coverage, you can be enrolled in the event of the loss of that other coverage. If you do not enroll within 60 days of the loss of other coverage, you must wait until the Annual Open Enrollment Period.

WHEN CAN YOU ENROLL YOUR DEPENDENTS

- You must be enrolled in order to enroll your eligible dependents.
- You can enroll your dependents at the time that you enroll or during any Annual Open Enrollment Period.

- If you have a new dependent, you may immediately enroll the dependent, but you must do so within 60 days of the dependents's eligibility. If you do not enroll the new dependent within 60 days, you must wait until the Annual Open Enrollment Period.

- If you did not enroll an eligible dependent because of other coverage, that dependent can be enrolled in the event of the loss of that other coverage. If you do not enroll that dependent within 60 days of the loss of other coverage, you must wait until the Annual Open Enrollment Period.

WHEN DOES YOUR COVERAGE BEGIN?

- If you enroll at the time you begin employment, your coverage begins approximately two months after the start of your employment. If you are paid through the State's Centralized Payroll Unit, your coverage begins after four full pay periods. If you are **not** paid through the State's Centralized Payroll Unit, your coverage begins on the 61st day of employment. (Note: See orthodontic exception below.) Coverage for enrolled eligible dependents is effective the same date as your coverage.

- If you enroll during the Annual Open Enrollment Period, your coverage begins on the effective date established for the Open Enrollment Period following the close of the Open Enrollment Period.

- If you enroll under the provisions described above because of loss of other coverage, your State Group Dental Program coverage begins with the next processing schedule date. If you want coverage retroactive to the date you lost the other coverage, you will be responsible for paying the appropriate premiums.

- If you enroll under the Dental Expense Plan (Indemnity Plan), your coverage for any eligible orthodontic expense becomes effective only after you have been employed for 10 months. If you elect a Dental Plan Organization (DPO), your coverage for eligible orthodontic expense becomes effective when your normal dental coverage begins (see first paragraph of this section).

WHEN DOES DEPENDENT COVERAGE BEGIN?

- If you enroll a dependent at the time that you enroll as a new employee, the dependent's coverage begins when your coverage begins (after approximately two months).

- If you add a new dependent during the 60-day period before or after a qualifying event (birth, marriage, adoption, loss of coverage due to a dependent's change of employment, etc.), the dependent's coverage begins effective with the next processing schedule.

- For those dependents not added when eligible but whom you wish to add during the Annual Open Enrollment Period, the dependent's coverage begins on the effective date established for the Open Enrollment Period following the close of the Open Enrollment Period.

WHEN CAN YOU CHANGE OR CANCEL YOUR COVERAGE?

- You may switch from one plan to another only during the Annual Open Enrollment Period.

- You must remain in a plan for 12 months before you can transfer to another plan during the next Annual Open Enrollment Period.

- If you did not enroll an eligible dependent because of other coverage, that dependent can be enrolled in the event of the loss of that other coverage. If you do not enroll that dependent within 60 days of the loss of other coverage, you must wait until the Annual Open Enrollment.

- You may cancel your coverage at any time after 12 months of participation.

- You may cancel coverage for a dependent at any time after the dependent's 12 months of participation.

- If you enroll in a Dental Plan Organization (DPO), you may change your DPO only during the Annual Open Enrollment Period, or when your DPO cannot provide you a dental provider within 30 miles of your home.

WHEN DOES YOUR COVERAGE END?

The Dental Expense Plan and DPO coverage ends:

- If you are no longer eligible due to a change in your employee eligibility status, or

- If you fail to make the required payments for your enrollment.

- If you voluntarily terminate coverage after 12 months of participation.

WHEN DOES DEPENDENT COVERAGE END?

- When a dependent is no longer eligible, or

- When your coverage ends, or

- If you voluntarily terminate the dependent's coverage after 12 months of participation.

CAN I SAVE TAXES ON MY PREMIUMS AND CO-PAYMENTS?

- If you are a State employee, the premiums that you pay for dental plan coverage are exempt from federal taxes unless you have specifically declined participation in the Premium Option Plan of the State's Tax$ave Program. These premiums are deducted from your paycheck before Federal income, Social Security and Medicare taxes are taken out, thereby saving you money on taxes.

- If you have elected to establish an Unreimbursed Medical Spending Account under the Tax$ave Program, then any eligible out-of-pocket expense (co-payments, deductibles, coinsurances) that you make in the Program can be paid from that account. This also saves you tax dollars.

- Fact Sheet #44, which outlines the Tax$ave Program, may be obtained from your benefits administrator or from the Division of Pensions and Benefits by calling the Benefit Information Library (BIL) at (609) 777-1931 and entering #264 when prompted.

EXTENSION OF COVERAGE AFTER END OF ELIGIBILITY

Dental Expense Plan only:

If coverage for you or a dependent is terminated, the coverage will be extended to cover the following procedures for 30 days following the end of the coverage:

- An appliance or modification of an appliance for which the impression was taken while the person was covered;

- A crown or restoration for which a tooth was prepared while the person was covered;

- Root canal therapy for which the pulp chamber was opened while the person was covered.

DPOs only:

If coverage for you or a dependent is terminated (but the DPO continues to participate in the SHBP) the coverage will be extended to cover the following procedures to the completion of the procedure:

- An appliance or modification of an appliance for which the final impression was taken while the person was a covered individual;

- A crown or restoration for which a tooth was prepared while the person was a covered individual;

- Root canal therapy for which the pulp chamber was opened while the person was a covered individual.

EXTENSION OF COVERAGE TO CHILDREN OVER THE AGE OF 23

A child over the age of 23 who is incapable of self-support due to mental illness, mental retardation or physical disability, provided the child had been enrolled prior to reaching age 23 and the disability occurred before age 23 may be continued for coverage. You must prove the child is incapable of self-support and the continuation of coverage must be approved by the State Health Benefits Program (SHBP). To request continued coverage, call or write the Division of Pensions and Benefits, Health Benefits Bureau, for a Continuance for Dependent With Disabilities form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the Continuance for Dependent With Disabilities form. Coverage may continue only while (1) you are still

covered through the SHBP, (2) the child is disabled, and (3) the child is unmarried. The Division will contact you periodically to verify that the covered child remains eligible for continued coverage.

EXTENSION OF COVERAGE IF DPO TERMINATES PARTICIPATION IN SHBP

If your dental plan organization leaves the Program, coverage for you and your dependents will be extended (at no additional cost to you except the pro-rata portion of the co-payment) to cover any service started prior to plan termination, including a full course of orthodontic treatment.

COVERAGE DURING LEAVE OF ABSENCE

- If you are on an authorized leave with pay, your coverage is automatically continued.

CONTINUATION OF DENTAL BENEFITS

Status	Maximum Duration	Cost to Employee
Unpaid LOA for Illness and Personal Reasons (other than for family leave)	Six pay periods or three months	Full premium for level of coverage (employer and employee share)
Workers' Compensation (off payroll)	Duration of Workers' Compensation period	Employee share only
Family Leave (with or without pay)	Six pay periods or three months	Employee share only
Furlough	Duration of furlough	Employee share only
Extended Furlough	Duration of extended furlough	Full premium for level of coverage (employer and employee share)

- If you are on an authorized leave without pay, you may continue your coverage for up to six bi-weekly pay periods or three months. You must pay the entire cost (employee and employer contributions) in advance except in the case of Workers' Compensation, Family Leave, and Furlough. In these cases, you pay only the cost of the employee contribution.

COVERAGE AFTER ELIGIBILITY ENDS (COBRA)

Coverage for you and your dependents will end:

- If you discontinue your contributions;

- If you leave full-time employment in State government or if the Dental Plan Organization is discontinued. Coverage will end on the last day of the period for which contributions have been deducted from your pay;

- If you have a pending claim under Workers' Compensation for periodic benefits, the coverage for you and your dependents will continue until you retire or the periodic benefits under Workers' Compensation terminate, whichever occurs first, provided that you pay the required contribution for the coverage.

There is no conversion privilege allowing you to continue buying coverage through a separate individual contract if you leave State employment or retire. However, the Federal regulation known as COBRA gives you the right to purchase continuing coverage in this Program at your expense for a limited period of time, if your loss of coverage is a result of:

- Termination of employment, except for gross misconduct;
- Death of the member;
- Reduction in work hours;
- Leave of absence;
- Divorce (non-member spouse may be eligible for COBRA coverage);
- Dependent child ineligibility (marriage, attaining age 23, or no longer living at home).

The amount of time that you may continue to purchase coverage depends on the reason for your loss of coverage.

- Under COBRA guidelines, coverage may be purchased for up to 18 months if you and/or your dependents become ineligible for SHBP coverage because of termination of employment, a reduction in hours, or a leave of absence.

- Coverage for you and your covered dependents may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled through COBRA or incurred within 60 days of enrollment.

- Under COBRA guidelines, coverage may be purchased by a dependent for up to 36 months if your dependent becomes eligible for COBRA because of your death or divorce, or he/she becomes ineligible for continued group coverage because of marriage, attaining age 23, or moving out of the household.

- If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a maximum total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

- If you are on a leave of absence for illness or personal reasons prior to your loss of coverage, the time spent on leave in a covered status will count towards your COBRA term. For example, you are on a leave for illness and your employer continues your coverage for three months. You do not return to work and therefore lose your coverage. You elect to continue coverage under COBRA. You will be allowed to purchase coverage for 15 months - the 18 months of eligibility less the three months of coverage you had while on leave.

If you choose to purchase COBRA benefits, you pay 100% of the cost of the coverage plus an additional two percent for the cost of administration.

You do not have to enroll in the same dental plan under COBRA that you had as an Active Group member or as a dependent, but you cannot increase the level of coverage or add dependents. You may add dependents if there is a qualifying event (e.g. marriage, birth) or during the next Open Enrollment Period.

To purchase coverage under COBRA, you and/or your dependents must follow these procedures:

- Notify your employer (if you are already on COBRA, notify the Division of Pensions and Benefits, Health Benefits Bureau) that a divorce, or death has occurred or that your child has married, moved out of your household, or reached age 23. Written notification must be given within 60 days of the date the event occurred.

- File a COBRA Application within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later.

- Pay the required monthly premiums in a timely manner.

- Pay premiums, when billed, retroactive to the date of group coverage termination.

Your COBRA coverage will end when any of the following situations occur:

- Your eligibility period expires.

- You fail to pay your premiums in a timely manner.

- You become covered under another group insurance program (unless a preexisting clause applies).

- You voluntarily cancel your coverage.

APPEALS

Any member of the Dental Expense Plan who disagrees with a final decision of the insurance administrator (Prudential Insurance Company) may request, in writing, that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299 and must contain the reason for the disagreement and a copy of all relevant correspondence. Appeals are considered at regular monthly meetings of the Commission. It is the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

Any member of a DPO who disagrees with a determination of the appropriateness of a procedure made by a DPO or any member of a DPO who feels that the DPO has violated the terms and conditions of its contract with the SHBP may request, in writing, that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the DPO's grievance process. Upon request, your DPO will supply you with its grievance procedures. Requests for consideration must be directed to the Appeals

Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299 and must contain the reason for the disagreement and a copy of all relevant correspondence and supporting documentation. Appeals are considered at regular monthly meetings of the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request in writing to the Commission within 45 days that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law judge will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If not, the administrative appeal process is ended. When the administrative process is completed, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. If you take your appeal to Superior Court, you will be responsible for any court filing fees or similar related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

SECTION TWO
THE DENTAL EXPENSE PLAN

WHAT IS THE DENTAL EXPENSE PLAN?

The Dental Expense Plan is an indemnity plan that will reimburse you for a portion of the expenses you (and enrolled dependents) incur for dental care provided by any dentist or physician licensed to perform dental services. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount. (For example, orthodontic services are reimbursed differently than other services.) Each participant must first meet a deductible amount before expenses are reimbursed. You are responsible for making the full payment of all charges to your dentist. If you use a dental provider belonging to a special panel established by the plan administrator, normal charges will be discounted, thereby saving you money.*

The Dental Expense Plan has been established by the State as a self-insured plan. The State currently contracts with the Prudential Insurance Company to act solely as the administrative agent for the Plan, not as the insurer.

- For information concerning the Plan, including the services that are covered and the reimbursement amounts, please call Prudential at (609) 653-8876.

* Prudential Dental Provider Organization (PDO) - As a Dental Expense Plan member you may be able to take advantage of a special Prudential network of dental providers. In this network, called the Prudential Dental Provider Organization (PDO), participating dental providers contract with Prudential for a discounted fee schedule. When you use a PDO dental provider, you only pay the provider your deductibles and 20% coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. The PDO providers will submit the claims directly to Prudential, eliminating the necessity of your filing claim forms, and the Dental Expense Plan will pay the provider. To find out if your provider participates in the PDO network, call Prudential at 1-800-282-0555.

WHAT IS THE DEDUCTIBLE AMOUNT?

The first $25 of covered expenses that you or your dependent incur in a calendar year is not eligible for reimbursement. However, if there are four or more members of your family in the Plan, no additional deductibles are charged after any three members have each met their $25 deductible.

TO WHOM WILL PAYMENTS BE MADE?

Normally, reimbursements will be made to the Plan subscriber (the employee). The Plan subscriber may, however, authorize Prudential to send the reimbursement directly to the dental provider by completing the appropriate part of the claim form.

Additionally, whenever a law or court order requires the payment of dental expense benefits under the Plan to be made to a person or facility other than the subscriber, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

WHAT IS THE REIMBURSEMENT FORMULA?

After a person meets his or her $25 deductible, then the costs of all other eligible services for that person are reimbursed at the rate of 80% of the reasonable and customary charge for the service (except where certain limits apply).

HOW IS A "REASONABLE AND CUSTOMARY CHARGE" DETERMINED?

The "reasonable and customary charge" is based on actual charges submitted by dentists in your area for a particular service. It may differ from the actual amount that your dentist charges.

IS APPROVAL IN ADVANCE EVER REQUIRED?

You must obtain approval in advance from the Prudential Insurance Company whenever:

- the service is part of a Treatment Plan that will result in total charges of at least $300; or
- the service includes charges for crowns, inlays or onlays, regardless of the cost.

ARE THERE ANY EXCEPTIONS FOR APPROVAL IN ADVANCE?

Yes. An advance approval is not required for services rendered for emergency care.

WHAT SERVICES ARE ELIGIBLE FOR REIMBURSEMENT?

(Some of the terms in this section may be unfamiliar to you. Please see the Glossary on page 31.)

- Oral exams (limited to twice each calendar year)
- X-rays.
- Oral prophylaxis, including scaling (not including scaling performed by a periodontist) and polishing (limited to two treatments each calendar year.)
- Topical application of fluoride for children under age 19.
- Restoration of prosthodontic devices (labor and supplies) to a condition where they again perform all functions for which they were designed.
- Restorative procedures, including fillings (other than gold), inlays and crowns (not used as a bridge or a bridge abutment).
- Emergency palliative treatment.
- Extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers.
- Oral surgery for surgical extractions, treatment of fractures, removal of lesions of the mouth, and alveolectomy.

- Apicoectomy

- General anesthesia when appropriate for, or associated with, the following procedures or circumstances:

    - *Oral surgery*

    - *Mental retardation*

    - *Spastic disease*

    - *Infection at site of injection/failure to obtain effective local anesthesia due to acute infection*

    - *Allergy to local anesthesia*

    - *Patient management of eligible dependent children (due to hyperactivity, etc.)*

WHAT CHARGE LIMITS APPLY TO THESE SERVICES?

- A charge for repairs of prosthodontic devices will not include a charge for: stress-breakers; precision attachments; semi-precision attachments; keyways; mucosal inserts for dentures; coping and special attachments; overdentures; crowns; inlays and onlays needed to repair full or partial dentures unless necessary for other reasons; repairs to bridges, pontics and abutment crowns.

- Two or more services may each be suitable for the dental care of a specific condition, under usual dental practice. If a charge is incurred for one of these services, Prudential may consider the charge to have been incurred for the other service which would have produced a professionally acceptable result, as determined by Prudential and may pay only the lower of the two services.

WHAT SERVICES ARE NOT ELIGIBLE FOR REIMBURSEMENT?

- Any orthodontic service prior to the employee attaining 10 months of employment or for any member over 19 years of age (see the separate section for special coverage for orthodontic service).

- A set of full mouth X-rays more often than once every three years.

- More than 12 films per set of mouth X-rays.

- Bitewing X-rays more than twice in a calendar year.

- Any periodontic procedure.

- Any prosthodontic procedure or device used to replace missing teeth.

- Gold restorations other than crowns, inlays and onlays.

- Any service or item not reasonably necessary for the dental care of the patient.

- Tooth implants, sealants, protective devices such as athletic mouth guards, plaque control, or myofunctional therapy.

- A procedure to alter vertical dimensions or restore occlusion.

- Crowns, inlays or onlays if used in splinting procedures during periodontal treatment.

- A service for cosmetic purposes.

- Any charge for a supply that is normally for home use such as toothpaste, toothbrushes, water-pik or mouthwash.

- A dental examination when required as a condition of employment by an employer, a government agency, or the terms of a labor agreement.

- A service or material which was furnished only because the charge would be paid under the Program coverage.

- A service or supply due to a war or any act of war.

- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.

- A service rendered by a provider that is beyond the scope of the provider's license.

- A charge made by a dentist for a failure of the patient to keep an appointment.

- A charge for the completion of any claim forms.

- A charge in connection with any procedure started before the patient was eligible for reimbursement in this Program; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.

- Any service or supply other than those specifically covered under this Program.

- Any service or supply which is furnished or made available to a patient or financed by Federal, State or Local Government, including Medicare or a like program, Workers' Compensation law or a similar law, any automobile no-fault law, or any other program or law under which the patient is or could be covered, whether or not the patient makes any claim or receives compensation under it; or any recovery made by the patient from a third party for damages.

- Any charge incurred after the patient is no longer covered, except in the case of an Extension of Coverage.

- Any charge for a service that is more than the reasonable and customary dental charge.

- Any charge for a service rendered by a relative.

ARE ORTHODONTIC SERVICES ELIGIBLE FOR REIMBURSEMENT?

Certain charges for orthodontic procedures are eligible if:

- You have been a full-time employee in the Program for at least 10 months.

- The orthodontic treatment is for a child covered in the Program who is less than 19 years old.

- The procedure involves the use of active appliances to move teeth in order to correct the faulty position of teeth (malposition) or abnormal bite (malocclusion) and is needed to correct one of these conditions:

    - *vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet) of at least four millimeters.*

    - *faulty alignment (either frontwards or backwards) of the upper and lower arches with each other by at least the width of one tooth section (one cusp).*

    - *cross-bite.*

- The service or supply is part of a Treatment Plan submitted by the dentist and approved by Prudential with an estimate of the benefits that are payable.

- The service or supply is furnished before the end of the estimated duration of the treatment as recorded in the Treatment Plan.

- An active appliance for the procedure is inserted while the person is eligible for benefits in this Program.

WHAT ARE THE ORTHODONTIC BENEFITS?

Benefits for the eligible charges as described in a Treatment Plan are:

- Diagnosis (once every five years) $50

- Active treatment, including appliances:
  First month $50
  Each subsequent month 25
  Lifetime maximum 700
  Retention treatment per visit (five visit lifetime limit 10

HOW ARE ORTHODONTIC BENEFITS PAID?

The total estimated eligible charges, as determined by the Treatment Plan, are paid in installments during the duration of treatment as follows:

- Payments are made on the date that the appliances are first inserted, and at the end of each month thereafter.

The payments will be in equal amounts, except the first payment will be twice the amount of all other payments.

WHAT ORTHODONTIC CHARGES ARE NOT ELIGIBLE?

- Charges that are eligible for coverage under the regular dental care portion of the program.

- Charges for an orthodontic procedure started prior to the day on which the person became covered under the program.

- Charges not reasonably necessary for orthodontic care.

- Any charges incurred for orthodontic procedures treatment begun on a person on or after the date the person attains age 19.

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between the two State Dental Plans because no individual is eligible for coverage in more than one State Dental Plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the basic determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the Dental Expense Plan.

- If your spouse is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse's primary coverage is through the dental plan offered by his or her employer.

- If your children are enrolled as dependents in your plan and your spouse's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse's plan does not follow this rule, then the rule in the other program will determine the order of benefits.

- In the case of a separation or divorce, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse of the parent with custody of the child; or by the plan of the noncustodial parent.

SECTION THREE
THE DENTAL PLAN ORGANIZATIONS

WHAT IS A DENTAL PLAN ORGANIZATION?

A Dental Plan Organization is similar to a medical HMO program. The full cost for most services are prepaid to your dentist, but certain services require an additional co-payment from you. Also, if you choose a more expensive treatment than deemed appropriate by your dental provider, you must pay the extra cost. Further, you will not be covered for services if you go to a dentist who is not a member of your DPO, unless referred by your DPO.

There are many Dental Plan Organizations in the State Program. Among these organizations, there are two types of plans -- Dental Center Plans and Individual Practice Associations (IPA).

- Dental Centers employ a group of dentists and technicians who are located at a central office. In a Dental Center Plan, you do not have the option to select a particular dentist unless permitted by the dental center.

- An Individual Practice Association (IPA) consists of a network of participating dentists who work in their own offices. If you choose an IPA, you must select a specific dentist in the IPA who will treat you and your dependents.

Some DPOs offer both a dental center and a list of participating dentists, thereby giving you the option of selecting a center or a particular dentist.

The DPO is responsible for providing all of the services that are listed as covered on pages 20 to 29 of this booklet. If the participating dentist that you have selected does not provide a specific service, then the DPO must refer you to another participating dentist located within 10 miles of your dentist's office (or 20 miles for orthodontic service). If you agree, the DPO may also refer you to a dentist located beyond these limits.

If the DPO has no participating dentist who can provide the service in your geographical area, then the DPO must refer you to a nonparticipating dentist within the 10 or 20 mile limit. If there is no dentist within this area, then you must be referred to the dentist closest to your dentist's office.

- If the DPO dentist refers you to another dentist and that referral is approved by the DPO, then you will have the same coverage for the service as if you had been treated by your dentist. However, if you select an outside dentist on your own, the service you receive will not be covered.

CONSIDERATIONS IN CHOOSING A DPO

- Obtain a list of DPOs and participating dentists from your benefits administrator. If you choose a dentist rather than a dental center, double-check with the DPO and the dentist to be sure that the dentist is a member of the DPO, services State Dental Program members and will accept you as a new patient.

- If you choose a dentist, you should also check with the dentist to make sure that he or she plans to stay in the DPO. If the dentist leaves, you will then have to select another dentist in that DPO.

- You should also check to determine that the DPO dentist or center can serve the needs of your entire family and whether the days and hours of operation are convenient for you and your family.

- If your dentist leaves the DPO, and there are no other dentists in the DPO within 30 miles of your home, you may switch to another dental plan (either another DPO or the Dental Expense Plan).

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between the two State Dental Plans because no individual is eligible for coverage in more than one State Dental Plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the basic determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the DPO.

- If your spouse is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse's primary coverage is through the dental plan offered by his or her employer.

- If your children are enrolled as dependents in your plan and your spouse's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse's plan does not follow this rule, then the rule in the other program will determine the order of benefits.

- In the case of a separation or divorce, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse of the parent with custody of the child; or by the plan of the noncustodial parent.

WHAT SERVICES ARE COVERED?

The following is a list of covered services and if applicable, copayments. Copayment means what you must pay for the service. Some of these terms may be unfamiliar to you. Please see the Glossary on page 31.

Codes are effective as of March 1, 1998.

Codes	Description of Covered Services	Copayments
00100-00999	**I. DIAGNOSTIC**	
Clinical Oral Examination		
(Limited to twice in any period of 12 consecutive months)		
00120	Periodic Oral Evaluation	$0

Codes	Description of Covered Services	Copayments
Clinical Oral Examination (continued)		
00140	Limited Oral Evaluation	$0
00150	Comprehensive Oral Evaluation *(formerly 00110)*	0
00160	Detailed and Extensive Oral Evaluation	0
Radiographs		
00210	Intraoral-Complete Series Including Bitewings	$0
	(Limited to once in any period of 36 consecutive months)	
00220	Intraoral-Periapical-First Film	0
00230	Intraoral-Periapical-Each Add Film	0
00240	Intraoral-Occlusal Film	0
00250	Extraoral-First Film	0
00260	Extraoral-Each Additional Film	0
00270	Bitewings-Single Film	0
00272	Bitewings-Two Films	0
00274	Bitewings-Four Films	0
00290	Posterior-Anterior or Lateral Skull and Facial	0
	Bone Survey Film	0
00330	Panoramic Film	0
00340	Cephalometric Film	0
Tests and Laboratory Examinations		
00415	Bact Studies for Determ Path Agents	$0
00425	Caries Susceptibility Tests	0
00460	Pulp Vitality Tests	0
00470	Diagnostic Casts	0
01000-01999 II. PREVENTIVE		
Dental Prophylaxis		
(Limited to twice in any period of 12 consecutive months)		
01110	Prophylaxis-Adult	$0
01120	Prophylaxis-Child	0
Topical Fluoride Treatment *(Office Procedure)*		
(Limited to twich in any period of 12 consecutive months)		
01201	Top Appl Fluor Incl Prophy-Child	$0
01203	Top Appl Fluor Excl Prophy-Child	0
01204	Top Appl Fluor Excl Prophy-Adult	0
01205	Top Appl Fluor Incl Prophy-Adult	0
Other Preventive Services		
01330	Oral Hygiene Instruction	$0
01351	Sealant-Per Tooth	0
Space Maintenance *(Passive Appliances)*		
01510	Space Maintainer-Fixed Unilateral	$0
01515	Space Maintainer-Fixed Bilateral	0
01520	Space Maintainer-Removable-Unilateral	0
01525	Space Maintainer-Removable--Bilateral	0
01550	Recementation of Space Maintainer	0

Codes	Description of Covered Services	Copayments
02000-02999	**III. RESTORATIVE**	
Amalgam Restorations *(Including Polishing)*		
02110	Amalgam-One Surface Primary	$0
02120	Amalgam-Two Surfaces Primary	0
02130	Amalgam-Three Surfaces Primary	0
02131	Amalgam-Four or More Surfaces Primary	0
02140	Amalgam-One Surface Permanent	0
02150	Amalgam-Two Surfaces Permanent	0
02160	Amalgam-Three Surfaces Permanent	0
02161	Amalgam-Four or More Surfaces Perm	0
Silicate Restorations		
02210	Silicate Cement-Per Restoration	$0
Resin Restorations		
02330	Resin-One Surface Anterior	$0
02331	Resin-Two Surfaces Anterior	0
02332	Resin-Three Surfaces Anterior	0
02335	Res->3 Sur or Inv Incisal Angle Ant	0
02336	Composite Resin Crown-Anterior-Prim	0
02380	Resin-One Surface Posterior-Primary	0
02381	Resin-2 Surfaces Posterior-Primary	0
02382	Resin->2 Surfaces Posterior-Primary	0
02385	Resin-1 Surface Posterior-Permanent	0
02386	Resin-2 Surfaces Posterior-Permanent	0
02387	Resin->2 Surfaces Posterior-Permanent	0
Inlay/Onlay Restorations		
02510	Inlay-Metallic-1 Surface	$60
02520	Inlay-Metallic-2 Surfaces	60
02530	Inlay-Metallic-3 or More Surfaces	60
02543	Onlay-Metallic-3 Surfaces	60
02544	Onlay-Metallic-4 or More Surfaces	60
02610	Inlay-Porcelain/Ceramic-1 Surface	75
02620	Inlay-Porcelain/Ceramic-2 Surfaces	75
02630	Inlay-Porcelain/Ceramic-3 or More Surfaces	75
02642	Onlay-Porcelain/Ceramic-2 Surfaces	75
02643	Onlay-Porcelain/Ceramic-3 Surfaces	75
02644	Onlay-Porcelain/Ceramic-4 or More	75
02650	Inlay-Composite/Resin-1 Surface *(Lab Processed)*	75
02651	Inlay-Comp/Resin-2 Surface *(Lab Processed)*	75
02652	Inlay-Comp/Resin-3 or More Surfaces*(Lab Processed)*	75
02662	Onlay-Comp/Resin-2 Surfaces *(Lab Processed)*	75
02663	Onlay-Comp/Resin-3 Surf *(Lab Process)*	75
02664	Onlay-Comp/Resin-4+ Surf *(Lab Process)*	75

Codes	Description of Covered Services	Copayments
Crowns - Single Restorations Only		
02710	Crown-Resin-Laboratory (*Note)	$ 75
02720	Crown-Resin with High Noble Metal	125
02721	Crown-Resin with Predominantly Base Metal	125
02722	Crown-Resin with Noble Metal	125
02740	Crown-Porcelain/Ceramic Substrate	175
02750	Crown-Porcelain Fused to High Noble Metal	175
02751	Crown-Porcelain Fused to Predomin Base Metal	175
02752	Crown-Porcelain Fused to Noble Metal	175
02790	Crown-Full Cast High Noble Metal	175
02791	Crown-Full Cast Predominantly Base Metal	175
02792	Crown-Full Cast Noble Metal	175
02810	Crown-3/4 Cast Metallic	175
Other Restorative Services		
02910	Re-cement Inlay	$0
02920	Re-cement Crown	0
02930	Prefabricated Stainless Steel Crown-Primary Tooth	25
02931	Prefab Stainless Steel Crown-Permanent Tooth	25
02932	Prefabricated Resin Crown	25
02933	Prefab Stainless Steel Crown with Resin WDW	25
02940	Sedative Fillings	0
02950	Buildup Including Any Pins	0
02951	Pin Reten-Per Tooth in Add to Rest	0
02952	Cast Post & Core in Additon to Crown	25
02954	Prefabricated Post & Core in Addition to Crown	25
02955	Post Removal *(Not in Conjunction with Endodontic Therapy)*	0
02970	Temporary Crown *(Fractured Tooth)*	0
02980	Crown Repair - By Report	0
03000-03999 IV. ENDODONTICS		
Pulp Capping		
03110	Pulp Capping-Direct Excluding Final Restoration	$0
03120	Pulp Capping-Indirect Excluding Final Restoration	0
Pulpotomy		
03220	Therapeutic Pulpotomy Exc Fin Rest	$15
Endodontic Therapy on Primary Teeth		
03230	Pulpal Therapy (Resorbable Filling)-Anterior-Prim Tooth	$10
03240	Pulpal Therapy (Resorbable Filling)-Posterior-Prim Tooth	10

***Note**
There is no co-payment for procedure 02710 when performed in conjunction with a permanent crown on the same tooth.

Codes	Description of Covered Services	Copayments
Endodontic Therapy		
03310	Anterior (Excluding Final Restoration)	$75
03320	Bicuspid (Excluding Final Restoration)	75
03330	Molar (Excluding Final Restoration)	75
Endodontic Retreatment		
03346	Retreat Previous Root Canal-Anterior	$75
03347	Retreat Previous Root Canal-Bicuspid	75
03348	Retreat Previous Root Canal-Molar	75
Apexification/Recalcification Procedures		
03351	Apexification/Recalcification-Initial Visit	$25
03352	Apexification/Recalcification-Interim Medication Replmt	25
03353	Apexification/Recalcification-Final Visit	25
Apicoectomy/Periapical Services		
03410	Apicoectomy/Periradicular Surg-Ant	$75
03421	Apico/Perirad Surg-Bicus First Root	75
03425	Apico/Perirad Surg-Molar First Root	75
03426	Apico/Perirad Surg-Each Add Root	25
03430	Retrograde Filling-Per Root	0
03450	Root Amputation-Per Root	25
Other Endodontic Procedures		
03910	Surgical Procedure for Isolation of Tooth w/Rubber Dam	$ 0
03920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	50
04000-04999 V. PERIODONTICS		
Surgical Services		
04210	Gingivectomy/Gingivoplasty-Per Quad	$ 75
04211	Gingivectomy/Gingivoplasty-Per Tooth	25
04220	Gingival Curettage-Surgical-Per Quadrant-By Report	25
04240	Gingival Flap Procedure Incl Root Planning-Per Quad	75
04249	Crown Lengthening-Hard Tissue	75
04250	Muco-Gingival Surgery-Per Quadrant	75
04260	Osseous Surgery (Inc Flap Entry & Closure)-Per Quad	150
04263	Bone Replacement Graft-1st Site in Quadrant	75
04264	Bone Replacement Graft-Each Addition Site in Quad	25
04266	Guide Tissue Regeneration-Resorbable Barrier	75
04267	Guide Tissue Regeneration-Nonresorbable Barrier	75
04270	Pedicle Soft Tissue Graft Procedure	150
04271	Free Soft Tissue Graft Procedure (Including Donor Site)	150
04273	Subepithelial Connective Tissue Graft Procedure	150
04274	Distal or Proximal Wedge Procedure	25

Codes	Description of Covered Services	Copayments
Adjunctive Periodontal Services		
04320	Provisional Splinting-Intracoronal	$ 0
04321	Provisional Splinting-Extracoronal	0
04341	Periodontal Root Planing-Per Quadrant	50
04355	Full Debride Compre Peridont E&D	50
Other Periodontal Services		
04910	Periodontal Maint Procedures After Active Therapy	$25
04920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist	0
05000-05999 VI. PROSTHODONTICS (REMOVABLE)		
Complete Dentures (Including Routine Post Delivery Care)		
05110	Complete Denture-Maxillary	$200
05120	Complete Denture-Mandibular	200
05130	Immediate Denture-Maxillary	200
05140	Immediate Denture-Mandibular	200
Partial Dentures (Including Routine Post Delivery Care)		
05211	Maxillary Partial Denture-Resin Base (Inc Any Conv'l Clasps, Rests and Teeth)	$150
05212	Mandibular Partial Denture-Resin Base (Inc Any Conv'l Clasps, Rests and Teeth)	150
05213	Max Partial Dent-Cast Metal Frmwk w/Resin Dent Bases (Inc any Conv'l Clasps, Rests & Teeth)	200
05214	Mandibular Partial Denture-Cast Metal Frk w/Resin Denture Bases (Inc any Conv'l Clasps, Rest & Teeth)	200
05281	Removable Unilateral Partial Denture-One Piece Cast Metal (Incuding Clasps & Teeth)	100
Adjustments to Removable Prostheses		
05410	Adjust Complete Denture-Maxillary	$0
05411	Adjust Complete Denture-Mandibular	0
05421	Adjust Partial Denture-Maxillary	0
05422	Adjust Partial Denture-Mandibular	0
Repairs to Complete Dentures		
05510	Repair Broken Complete Denture Base	$25
05520	Replace Missing or Broken Teeth-Complete Dent-Each Tooth	25
Repairs to Partial Dentures		
05610	Repair Resin Denture Base	$25
05620	Repair Cast Framework	25
05630	Repair or Replace Broken Clasp	25
05640	Replace Broken Teeth-Per Tooth	25
05650	Add Tooth to Existing Part Denture	25
05660	Add Clasp to Existing Part Denture	25

Codes	Description of Covered Services	Copayments
Denture Rebase Procedures		
05710	Rebase Complete Maxillary Denture	$75
05711	Rebase Complete Mandibular Denture	75
05720	Rebase Maxillary Partial Denture	75
05721	Rebase Mandibular Partial Denture	75
Denture Reline Procedures		
05730	Reline Complete Maxillary Denture-Chairside	$ 0
05731	Reline Complete Mandibular Denture-Chairside	0
05740	Reline Maxillary Partial Denture-Chairside	0
05741	Reline Mandibular Partial Denture-Chairside	0
05750	Reline Complete Maxillary Denture-(Lab)	25
05751	Reline Complete Mandibular Denture-(Lab)	25
05760	Reline Maxillary Partial Denture-(Lab)	25
05761	Reline Mandibular Partial Denture-(Lab)	25
Other Removable Prosthetic Services		
05810	Interim Complete Denture (Maxillary)	$75
05811	Interim Complete Denture (Mandibular)	75
05820	Interim Partial Denture (Maxillary)	50
05821	Interim Partial Denture (Mandibular)	50
05850	Tissue Conditioning-Maxillary	0
05851	Tissue Conditioning-Mandibular	0
06200-06999 IX. PROSTHODONTICS, FIXED		
Fixed Partial Denture Pontics		
06210	Pontic-Cast High Noble Metal	$175
06211	Pontic-Cast Predominantly Base Metal	175
06212	Pontic-Cast Noble Metal	175
06240	Pontic-Porcelain Fused to High Noble Metal	175
06241	Pontic-Porcelain Fused to Predom Base Metal	175
06242	Pontic-Porcelain Fused to Noble Metal	175
06250	Pontic-Resin with High Noble Metal	125
06251	Pontic-Resin with Predom Base Metal	125
06252	Pontic-Resin with Noble Metal	125
Fixed Partial Denture Retainers-Inlays/Onlays		
06520	Inlay-Metallic-Two Surfaces	$60
06530	Inlay-Metallic-Three or More Surfaces	60
06543	Onlay-Metallic-Three Surfaces	60
06544	Onlay-Metallic-Four or More Surfaces	60
06545	Retainer-Cast Metal for Resin Bonded Fixed Prosthesis	75
Fixed Partial Denture Retainers-Crown		
06720	Crown-Resin with High Noble Metal	$125
06721	Crown-Resin with Predominantly Base Metal	125
06722	Crown-Resin with Noble Metal	125
06750	Crown-Porcelain Fused to High Noble Metal	175

Codes	Description of Covered Services	Copayments
Fixed Partial Denture Retainers-Crown (Continued)		
06751	Crown-Porcelain Fused to Predom Base Metal	$175
06752	Crown-Porcelain Fused to Noble Metal	175
06780	Crown-3/4 Cast High Noble Metal	175
06790	Crown-Full Cast High Noble Metal	175
06791	Crown-Full Cast Predom Base Metal	175
06792	Crown-Full Cast Noble Metal	175
Other Fixed Partial Denture Services		
06930	Recement Fixed Partial Denture	$ 0
06970	Cast Post & Core in Addition to Bridge Retainer	25
06971	Cast Post as Part of Fixed Partial Denture	25
06972	Prefabricated Post & Core in Add to Bridge Retainer	25
06973	Core Buildup for Retainer Including Pins	0
06980	Fixed Partial Denture Repair-By Report	0
07000-07999 X. ORAL AND MAXILLOFACIAL SURGERY		
Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Post-Operative Care		
07110	Single Tooth	$15
07120	Each Additional Tooth	10
07130	Root Removal-Exposed Roots	15
Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Post-Operative Care		
07210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap & Removal of Bone and/or Section of Tooth	$25
07220	Removal of Impacted Tooth-Soft Tissue	50
07230	Removal of Impacted Tooth-Partially Bony	50
07240	Removal of Impacted Tooth-Completely Bony	50
07241	Removal of Imp'd Tooth-Completely Bony with Complications	50
07250	Surgical Removal of Residual Tooth Roots-Cutting Procedure	25
Other Surgical Procedures		
07260	Sedative Fillings	$75
07270	Tooth Reimplantation/Stabilization	50
07280	Surgical Exposure of Impacted/Unerupted Tooth-for Ortho Reasons	50
07281	Surgical Exposure of Impacted/Unerupted Tooth-to Aid Eruption	50
07285	Biopsy of Oral Tissue-Hard	20
07286	Biopsy of Oral Tissue-Soft	20
07291	Transseptal Fiberotomy-By Report	0

Codes	Description of Covered Services	Copayments
Alveoloplasty-Surgical Preparation of the Ridge for Dentures		
07310	Alveoloplasty in Conjunction with Extraction-Per Quad	$25
07320	Alveoloplasty Not in Conjunction with Extractions-Per Quad	25
Removal of Cysts, Tumors and Neoplasms		
07430	Excision of Benign Tumor-Lesion Up to 1.25cm Diameter	$50
07431	Excision of Benign Tumor-Lesion Greater Than 1.25cm Diameter	50
07450	Excision of Odontogenic Cyst or Tumor-Lesion Up to 1.25cm Diameter	50
07451	Excision of Odontogenic Cyst or Tumor-Lesion Greater than 1.25cm Diameter	50
07460	Excision of Non-Odontogenic Cyst or Tumor-Lesion Up to 1.25cm Diameter	50
07461	Excision of Non-Odontogenic Cyst or Tumor-Lesion Greater than 1.25cm Diameter	50
Excision of Bone Tissue		
07470	Removal of Exostosis-Maxilla or Mandible	$75
Surgical Incision		
07510	Incision & Drainage of Abscess-Intraoral Soft Tissue	$15
07520	Incision & Drainage of Abscess-Extraoral Soft Tissue	25
Other Repair Procedures		
07960	Frenulectomy-Separate Procedure	$50
07970	Excision of Hyperplastic Tissue-Per Arch	50
07971	Excision of Pericoronal Gingiva	25
Miscellaneous Services		
09110	Palliative (Emergency) Treatment of Dental Pain-Minor Procedure	$ 0
09211	Regional Block Anesthesia	0
09212	Trigeminal Div Block Anesthesia	0
09215	Local Anesthesia	0
09220	General Anesthesia-First 30 Minutes	25
09221	General Anesthesia-Each Additional 15 Minutes	10
09230	Analgesia	0
09240	Intravenous Sedation	25
09310	Consultation	0
09430	Office Visit Observation	0
09440	Office Visit After Hours	0
09610	Therapeutic Drug Injection By Report	0
09630	Other Drugs and/or Medications By Report	0
09910	Application of Desensitizing Med	0
09930	Treat Complications By Report	0

Codes	Description of Covered Services	Copayments
Miscellaneous Services (Continued)		
09940	Occlusal Guard-By Report	$25
09951	Occlusal Adjustment-Limited	0
09952	Occlusal Adjustment-Complete	50

ORTHODONTICS

(Treatment plan maximum of 24 months)

1. Patient under 18 years of age at the start of treatment — Class I, II and III malocclusion (co-payment required of $1,000 or 50% of bill, whichever is less).

2. Patient 18 years of age or over at the start of treatment — Class I, II and III malocclusion (co-payment required of $1,750 or 50% of bill, whichever is less).

WHAT SERVICES ARE NOT COVERED BY THE DPO?

- A service started before the person became a covered individual under the plan (except where the service was provided to the person as a covered individual under a DPO whose contract with the State was revoked or terminated).

- A service covered under any medical or surgical or major medical plan (including a health maintenance organization) provided by the employer.

- Replacement of lost, stolen or damaged prosthodontic devices within two years of the date of initial installation.

- A service not reasonably necessary for the dental care of a covered individual or provided solely for cosmetic purposes.

- Providing supplies of a type normally intended for home use, such as toothpaste, toothbrushes, waterpicks and mouthwash.

- A service required because of war or an act of war.

- A service made available to a covered individual or financed by the federal government or a state or local government. This includes the federal Medicare program and any similar federal program, any workers' compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.

- A service not furnished by a dentist. This is not applicable to a service performed by a licensed dental hygienist under the supervision of a dentist.

- General anesthesia, except when medically necessary in connection with covered oral surgery procedures.

- Hospitalization.

- Any implantation or experimental procedures. Any devices or appliances attached to implants.

- Appliances, restorations and procedures to alter vertical dimension and/or restore occlusion, including temporomandibular joint dysfunction, except oral splints.

- Procedures not listed on pages 20-29.

MORE EXPENSIVE SERVICES

A covered individual may elect a more expensive procedure than an appropriate procedure recommended by the DPO. The covered individual shall pay any co-payment required for the less expensive procedure plus the difference in cost between the two procedures on the basis of the reasonable and customary dental charges for the procedures.

SECTION FOUR
APPENDICES

APPENDIX A
GLOSSARY

Alveolectomy	Surgical excision of a portion of the dentoalveolar process, for recontouring the tooth socket ridge at the time of tooth removal in preparation for a dental prosthesis (denture).
Apicoectomy	Surgical removal of a dental root apex. Root resection.
Bitewing X-Ray	X-rays taken with the film holder held between the teeth and the film parallel to the teeth.
Crossbite	An abnormal relation of one or more teeth of one arch to the opposing tooth or teeth of the other arch.
Crown	That part of a tooth that is covered with enamel or an artificial substitute for that part.
Curettage	The removal of subgingival calcified deposits around the teeth and the cleaning of the gingival pocket.
Endodontics	Concerned with the biology and pathology of the dental pulp and surrounding tissues. Root canal.
Gingivectomy	Removal of gum tissue.
Gingivoplasty	A surgical procedure that reshapes and recontours the gum tissue in order to attain functional form.
Inlay	A filling for a dental cavity.
Mandibular	Relating to the lower jaw.
Maxillary	Relating to the upper jaw.
Myofunctional	Relating to the role of muscle function in the correction of orthodontic problems.
Onlay	A type of metal restoration that overlays the tooth to provide additional strength to that tooth.
Orthodontic	Concerned with the correction and prevention of irregularities of the teeth. Dental orthopedics.
Osteoplasty	Resection of the bony structure to achieve acceptable gum contour.

Palliative Treatment	Alleviation of symptoms without curing the underlying disease.
Periodontics	Concerned with the treatment of abnormal conditions and diseases of the tissues that surround and support the teeth.
Pontic	An artificial tooth on a fixed partial denture.
Prophylaxis	A series of procedures whereby calculus (calcified deposits), stain and other accretions are removed from the clinical crowns of the teeth and the enameled surfaces are polished.
Prosthodontics	The science of and art of providing suitable substitutes for crowns of teeth, or for replacing lost or missing teeth.
Pulpotomy	Removal of a portion of the pulp structure of a tooth, usually the coronal portion.
Temporo-mandibular	Denoting the joint of the lower jaw.

APPENDIX B

NEW JERSEY STATE DENTAL PLANS

UNIT/ DPO #	NAME	PHONE #	SERVING*
1	Atlantic Southern Dental Foundation	800-843-4727	All of New Jersey, Eastern Pennsylvania
2	Community Dental Associates	609-451-8844	Cumberland County
5	Cigna Dental Health, Inc.	800-367-1037	All of New Jersey, Eastern Pennsylvania, Parts of New York
6	Group Dental Health Administrators, Inc.	908-241-9700	Mercer, Union, Middlesex & Essex Counties
7	International Health Care Services	800-468-0600	All of New Jersey, Bucks County & Philadelphia
8	Oracare Dental Health Plan, Inc.	800-672-2273	All of New Jersey, Eastern Pennsylvania
11	Unity Dental Health Services, P.A.	800-648-0146	All of New Jersey
12	Flagship Health Systems Inc.	800-722-3524	All of New Jersey
14	Dental Group of New Jersey, Inc.	908-925-6022	North & Central Jersey
15	Statewide DPO, Inc.	800-839-8910	All of New Jersey
17	Managed Dental Choice	800-433-6825	All of New Jersey
18	John D Kernan, DMD, P.A.	609-962-6106	Camden County
19	Prudential DMO	800-843-3661	All of New Jersey, Eastern Pennsylvania
99	Dental Expense Plan - Administered by The Prudential	609-653-8876	Unrestricted

*For specific areas of service, contact the DPO or see your benefits administrator for a list of dental providers for each DPO.

APPENDIX C
DIVISION OF PENSIONS AND BENEFITS CONTACT INFORMATION

MAILING ADDRESSES:

Division of Pensions and Benefits
Office of Client Services
PO Box 295
Trenton, NJ 08625-0295

State Health Benefits Commission
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

On all correspondence, be sure to include your social security number and a daytime telephone number.

TELEPHONE NUMBERS:

(609) 292-7524
Division of Pensions and Benefits, Office of Client Services

Telephone Counselors available Monday through Friday (except holidays)
9:00 am to 4:00 pm

(609) 292-7718
TDD Phone (Hearing Impaired)

(609) 777-1931 Available 24 hours a day
Benefit Information Library (BIL)
For recorded data on the Group Dental Program select catalog number 256

(609) 984-7109 Available 24 hours a day
Recorded Directions to the Division of Pensions and Benefits

COUNSELING SERVICES:

Division of Pensions and Benefits
Office of Client Services
Third Floor
50 West State Street
Trenton, NJ 08625-0295

Counselors are available Monday through Friday (except holidays)
8:40 am to 4:00 pm
No appointment is necessary

Internet Home Page
http://www.state.nj.us/treasury/pensions